Barney Softness, M.D.
Suzanne Rosenfeld, M.D.
Michael Rosenbaum, M.D.
Lisa Thebner, M.D.
Adina Rusakov, M.D.

Patient Registration Form

Today's Date: ________________________

PATIENT INFORMATION

Patient's Last Name:	**First:**	**Middle:**

Birth date: / / Sex: **M** **F**	**Seen in Hospital?** **Y** **N** **If yes, Mother's Last Name in Hospital:**	**OB/GYN Name:** ____________________

Home Address: ______________________________ **Apt #:** _______ **City:** _______ **State:** ______ **Zip:** ___________	**Phone Number and Contact Informationb:** **Home Phone:** ( ) - ___________ - ____________ **Cell Phone:** ( ) - ___________ - ____________ **Work Phone:** ( ) - ___________ - ____________ **Additional Phone:** ( ) - ___________ - ____________ **Email Address:** ______________________________

GUARANTOR INFORMATION

Person Responsible for the Bill: ______________________________ **Birth Date:** / / **SSN:** - -	**Billing Address (if different than above):** ______________________________ **Apt #:** **City:** **State:** **Zip:**
Occupation:	**Employer:**

OTHER PARENT INFORMATION

Name: ______________________________ **Birth Date:** / / **SSN:** - -	**Home Address (if different than above):** ______________________________ **Apt #:** **City:** **State:** **Zip:**
Occupation:	**Employer:**

CLAIMS AUTHORIZATION

"I understand that the practice of West End Pediatrics, P.C. does not accept any form of insurance. Unless I have made prior alternative arrangements, I agree to make direct payment at time of service to the physician(s) of West End Pediatrics, P.C. for service furnished to me, regardless of compensation paid to me or my family by HMO's or insurance carriers.

Guarantors Signature:______________________________ **Date:** ______________________

PAYMENT AUTHORIZATION

Credit Card Type:	**VISA**	**MASTERCARD**	**AMEX**	**DISCOVER**

Credit Card Number:	**Expiration Date:**	**Security Code:**

Cardholder Signature:	**Print Name of Cardholder:**